# AGENCY WAITING LIST NOTIFICATION FORM

Applicant's name:

_____

First Last

Mailing address:

_____

Street

_____

City State Zip Code

Telephone number:

_____

**Please check the appropriate box below regarding how the WIC program will contact you:**

I ☐ do ☐ do not authorize the WIC program to leave voicemail messages at the phone number I provide to WIC.

I understand messages may contain information including but not limited to the WIC program name, applicant, participant and/or family name(s) and information related to appointments.

This section is for **CLINIC USE** only:

**1**. Date placed on waiting list: _____

**2.** Please circle one of the following options:

**a**. Potential / Actual Priority:

I II III IV V VI

**b.** Potential / Actual Category:

P B N I C

**3.** Complete a, b, or c as applicable:

**a**. P—EDC: _____

**b**. I/C—DOB: _____

**c**. N/B—Date pregnancy ended: _____

**4**. Referral to health and/or food/public assistance Program provided: _____

**5.** Date/time of appt for screening (if applicable):

_____

**It has been determined that you may meet the criteria to participate in the Idaho WIC program. Unfortunately, at this time funding is not available to provide services to all the applicants who may qualify. You are being placed on a waiting list and will be notified when it is possible for you to apply for program benefits.**

**You may appeal this decision by requesting a Fair Hearing. The request for a Fair Hearing must be made in writing within 60 days of the date of this letter. You may contact the local agency WIC Coordinator to request a form (CFR 246.9 *Fair Hearing Procedures*).**



**X** _____

**Signature of Applicant and/or Responsible Adult** **Date**

**X** _____

**Signature and Title of Clinic Staff** **Date**

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

# A. LOCAL AGENCY WAITING LIST: Transferring Clients (VOC)

| Initial contact date | Date placed on waitlist | Applicant's Name | Telephone # and Address | Category ( P B N I C) | Appt. date/time | Comments | Staff initials | Date notified of status | Date off waitlist/ Reason |
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IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN



# B. LA WAITING LIST PRIORITY LEVEL I: Medical - P, B, and I

| Initial contact date | Date placed on waitlist | Applicant's Name | Telephone # and Address | Household size & income | Category/ Infant age/DOB and/or EDC | Appt. date/time (If applicable) | Comments | Staff initials | Date notified of status | Date off waitlist/ Reason |
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IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

# C. LA WAITING LIST PRIORITY LEVEL II: Infant of WIC Mom

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|---|---|---|---|---|---|---|---|---|---|---|
| **Initial contact date** | **Date placed on waitlist** | **Applicant's Name** | **Telephone # and Address** | **Household size/income** | **Infant age/DOB** | **Appt. date/time (If applicable)** | **Comments** | **Staff initials** | **Date notified of status** | **Date off waitlist/ Reason** |
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IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN



# D. LA WAITING LIST PRIORITY LEVEL III: Medical - Children

| Initial contact date | Date placed on waitlist | Applicant's Name | Telephone # and Address | Household size/income | Child age/DOB | Appt. date/time (If applicable) | Comments | Staff initials | Date notified of status | Date off waitlist/ Reason |
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IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

# E. LA WAITING LIST PRIORITY LEVEL IV: Nutrition – Homeless (H), Migrant (M), P, B, and I

| Initial contact date | Date placed on waitlist | Applicant's Name | Telephone # and Address | Household size/income | Category/ Infant age/DOB and/or EDC | Appt. date/time (If applicable) | Comments | Staff initials | Date notified of status | Date off waitlist/ Reason |
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IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

# F. LA WAITING LIST PRIORITY LEVEL V: Nutrition – Homeless (H), Migrant (M) and C

| Initial contact date | Date placed on waitlist | Applicant's Name | Telephone # and Address | Household size/income | Child age/DOB | Appt. date/time (If applicable) | Comments | Staff initials | Date notified of status | Date off waitlist/ Reason |
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IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

# G. LA WAITING LIST PRIORITY LEVEL VI: Nutrition & Medical – Homeless (H), Migrant (M) and N

| Initial contact date | Date placed on waitlist | Applicant's Name | Telephone # and Address | Household size/income | Date pregnancy ended | Appt. date/time (If applicable) | Comments | Staff initials | Date notified of status | Date off waitlist/ Reason |
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